

STATE OF UTAH - LABOR COMMISSION
Division of Industrial Accidents
P.O. BOX 146610
SALT LAKE CITY, UTAH 84114-6610

ATTENDING PHYSICIAN'S STATEMENT

TO THE APPLICANT: Prior to mailing this form to the last physician who treated you in the state of Utah, please complete the following:

Your Complete Name: _____

Your Complete Current Mailing Address: _____

Date of Injury: _____ Social Security Number: _____

Employer _____ Insurance Carrier _____

TO THE PHYSICIAN: Please complete this form and mail it to the Labor Commission, Division of Industrial Accidents, 160 East 300 South, 3rd Floor, P.O. Box 146610, Salt Lake City, UT 84114-6610, (801)530-6800, AS SOON AS POSSIBLE.

1. Condition of Employee when last examined:

Date of Last Examination: _____

2. If Applicant is not released to return to work at time of last examination, please provide your best professional opinion as to the following:

- a. Estimated date of stabilization or return to work.
- b. Additional medical treatment required.
- c. Probability and extent of permanent partial impairment.

3. If attending physician is responsible for referring injured employee to another physician, clinic, or hospital, please indicate to which doctor, clinic, or hospital and provide the address thereof. Please give a brief explanation of your referral.

Printed Name of Attending Physician

Signature of Attending Physician

Number, Street, and Suite #

City/State/Zip

Date of this Report: _____

Street Address: Heber Wells Bldg, 160 East 300 South, 3rd Floor, Salt Lake City, UT